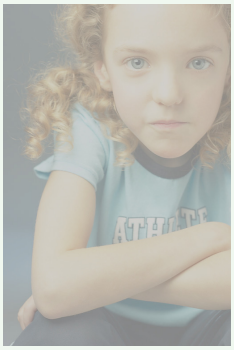
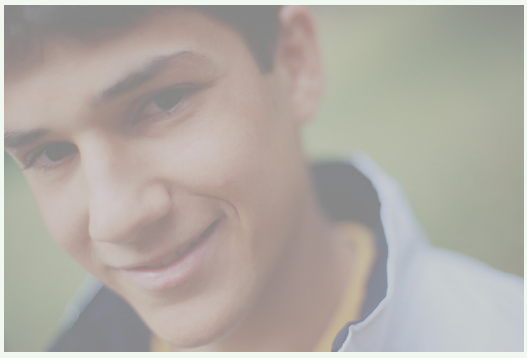
REPORT TO THE TWENTY-THIRD LEGISLATURE
STATE OF HAWAII
2005

PURSUANT TO HRS 321-176
REQUIRING EVERY TWO YEARS THE DEPARTMENT "SHALL SUBMIT TO THE LEGISLATURE AND THE GOVERNOR, A REPORT SETTING FORTH A DETAILED ANALYSIS OF THE PROGRESS MADE TOWARD FULLFILLING THE STATEWIDE PLAN" DEVELOPED IN ACCORDANCE WITH HRS 321-175

PREPARED BY:

DEPARTMENT OF HEALTH
STATE OF HAWAII
JANUARY, 2005

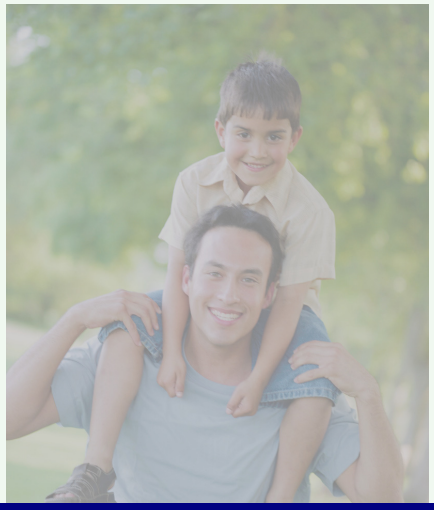




Child and Adolescent Mental Health Division

•happy children•healthy families•helpful communities

Progress toward fulfilling the Strategic Plan 2003-2006 Accomplishments and Updates December 2004



Hawai`i State Department of Health

▪ healthy people ▪ healthy communities ▪ healthy islands

Child and Adolescent Mental Health Division

•happy children

•healthy families

•helpful communities

The mission of the Child & Adolescent Mental Health Division is to provide timely and effective mental health services to children and youth with emotional and behavioral challenges, and their families.

During 2002 the Child and Adolescent Mental Health Division (CAMHD) and its stakeholders participated in a strategic planning process that led to the publication of Child & Adolescent Mental Health Services Strategic Plan 2003 – 2006 (the Plan). This plan marked an important step in the evolution of Hawaii's children's mental health system. By engaging broadly with stakeholders input was obtained from all child serving entities, community organizations, provider agencies, legislative representatives, and family members.

Over the past several months and with the same broad engagement we have requested feedback from our internal and external shareholders with the goal of reporting on the progress made toward meeting the performance measures of the Plan and updating Year 3 and Year 4, if necessary. We also took this opportunity to consider revisions to our Vision and Mission, and to identify gaps or weak areas of the Plan. Our revised Vision and Mission are introduced in this report. Gaps and areas for continued improvement are also noted.

Overall we met 78% of the 110 interim measures of the plan. 100% of the measures for adherence to evidence-based practices were met or partially met. 97% of the measures for quality and accountable business practices were met or partially met. Interim measures for shared ownership, adherence to Guiding Principles and evaluation of performance data and application of findings were met or partially met to a lesser extent.

Significant personnel and fiscal efforts were diverted from the Plan to achieve status as a behavioral health plan for QUEST and Medicaid Fee-for-service youth. These efforts were well rewarded with our recent overall rating of 96% (2004 Quality Assessment and Performance Improvement evaluation). Other performance measures were not met due to competing priorities both in the Department of Health budget and within other areas of the state budget.

Hawaii's system of care and evidence-based services development are receiving national recognition. I would like to personally thank our entire staff, providers, the legislature, stakeholders and most importantly the children, young adults and families who have provided the foundation for Hawaii's system of care.

Mahalo nui loa,

Christina Donkervoet, Chief CAMHD December 2004

This and CAMHD referenced documents are available at http://www.hawaii.gov/health/mental-health/camhd/index.html.

Process and Statutory Requirement

The Child & Adolescent Mental Health Services Strategic Plan 2003 – 2006 (the Plan) was developed in 2002 to serve as the foundation for the development of the Child & Adolescent Mental Health Division's (CAMHD) broad goals and key strategic initiatives.

This Plan marked an important step in the evolution of Hawaii's children's mental health system. By engaging broadly with various stakeholders, input was obtained from all child serving entities, community organizations, provider agencies, legislative representatives, and family members. This input served as the foundation for the development of five broad goals and a Management Plan (attached as an integral part of the Plan) setting forth the implementation strategy, timetable, responsibility and performance measure for each goal.

The Plan was written to address the Department of Health's statutory requirements to meet the needs of the children and youth needing mental health services (Hawaii Revised Statutes at §321-171 to174). Hawaii Revised Statutes (HRS) at §321-176 provides for a biennial review of progress.

> *§321-176 Every two years, starting January 1, 1979, the department of health, on or before January 1 of each two-year cycle, shall submit to the legislature and the governor a report setting forth:*
>
> *(1) A detailed analysis of the progress made toward fulfilling the statewide children's mental health services plan developed under section 321-175; and*
>
> *(2) Other matters which are necessary or appropriate, including recommendations for any amendment to any law, any change in the administrative practices and patterns of organization, the current and prevailing memoranda of agreement, and any change in the levels and patterns of financial support.*

This report serves to update the CAMHD broad group of stakeholders on the status of meeting the performance measures of the first two years of the Plan and report to the Legislature per HRS 321-176 including any changes in law, practice, organization and level and pattern of financial support.

Beginning in June 2004 the CAMHD staff began meeting statewide with child serving entities, community organizations, provider agencies, legislative representatives, and family members (herein after referred to as Stakeholder or Stakeholders) with the purpose of gathering feedback to measure the progress made toward fulfilling the Plan. The process was also designed to provide additional information that will aid in updating the Plan and other changes provided for in the statute. The majority of the feedback was obtained in facilitated small group discussions. The Plan has been available on the Department of Health (DOH), CAMHD web site since publication in late 2002. The first inquiry was generally a question about the participants' awareness of the Plan. Depending on the Stakeholder awareness of the Plan further discussions were focused on the five major goals:

- Shared ownership
- Adherence to Guiding Principles (Hawaii CASSP)
- Adherence to evidence-based practices
- Evaluation of performance data and application of findings
- Quality and accountable business practices

Overall feedback was requested to assess, from the Stakeholder perspective, whether the CAMHD had been effective or successful in meeting the intermediate goals of the Plan. Specific feedback was requested to provide information on populations (such as homeless, underinsured) or services that are not addressed by the Plan.

Information gathered in this process was a component of the assessment of determination as to whether the performance measure was met, met (partial) or not met. Additionally the public documents available on the CAMHD web site were used to assess the status of the performance measure.

In addition the CAMHD convened managers, staff, contracted providers and family members to:

- consider revisions to its Vision and Mission,
- share feedback received on the status of year 1 and 2 Management Plan goals,
- identify additional information necessary to complete the evaluation of year 1 and 2 Management Plan goals,
- identify gaps or weak areas of the Plan and
- discuss the next steps in the review process.

Appendix A provides information from the Management Plan for year 1 and year 2 (2003 and 2004) including the implementation strategy, performance measure and the assessment of status through the publication of this report, December 2004. Please see the specific list of definitions and explanations of terms that follow Appendix A.

Introduction of Vision and Mission

As provided in the Plan the CAMHD's mission and vision are as follows:

CAMHD VISION	CAMHD MISSION
Hawaii will provide the necessary supports and services that will allow children, youth and families to lead fulfilling and productive lives. These services and supports will be provided in caring communities throughout the state. These services and supports will effectively and efficiently address the individualized needs of children/youth with emotional and behavioral challenges.	The mission of the Child & Adolescent Mental Health Division is to provide timely and effective mental health services to children and youth with emotional and behavioral challenges, and their families. These services shall be provided within a system of care that integrates Hawaii's Child & Adolescent Service System Program (CASSP) principles, evidence-based services, and continuous monitoring efforts.

There was general concensus among the participants at the August retreat that the vision and mission needed to be shorter, more concise and meaningful to all Stakeholders.

In addition, the Department of Health has recently engaged in a process that more clearly defines the Departmental vision and is in the process of developing a strategic plan consistent with the ten essential public health services.

Taking into consideration the discussion at the management retreat and Stakeholder feedback a new vision and mission is presented with this report. Consistent with the overall Department of Health vision statement of "Healthy People, Healthy Communities, Healthy Islands" the following are presented as the revised CAMHD vision, mission and guiding principles.

•happy children **•healthy families** **•helpful communities**	**The mission of the Child & Adolescent Mental Health Division is to provide timely and effective mental health services to children and youth with emotional and behavioral challenges, and their families.**
Philosophy	**Access to evidence-based treatment services and supports will be provided to youth and families across the state so that they can fully engage in productive lives in their communities.**

Guiding Principles (Hawaii CASSP)

System of Care – CAMHD reaffirms its commitment to the system of care principles as developed by the Hawaii Task Force in 1993, and adapted from the original work of Stroul, B.A. and Friedman, R.M, 1986). The Hawaii Child and Adolescent Service System Program (CASSP) Principles are referred to as Guiding Principles (Hawaii CASSP) in this document. Appendix B lists the Hawaii CASSP in their entirety. Where capitalized as System of Care the words refer to these guiding principles.

- Respect for Individual Rights - the rights of children will be protected and promoted
- Individualization - the services are child and family centered, culturally competent and developed on the unique strengths of each individual and their family
- Early Intervention - early identification of social, emotional, physical and educational needs will be promoted in order to enhance the likelihood of successful early interventions and lessen the need for more intensive and restrictive services
- Partnerships with Youth and Families – families and youth, as much as indicated, will be full participants in the planning and service delivery
- Family Strengthening – family strengthening and the promotion of physical and emotional well-being are emphasized
- Access to Comprehensive Array of Services - a comprehensive array will be available to address unique needs of all youth and their families
- Community Based Service Delivery – a comprehensive array of services are available in all communities, with management and decision making of individualized treatment services maintained at the community level
- Least Restrictive Interventions – the services will be within the most natural environment, appropriate to individual needs
- Coordination of Services – the System of Care will include effective mechanisms to ensure services are coordinated, therapeutic and that each child can move through the system based on need

Goals

- Ensure shared ownership of the vision, mission, and commitment to children's mental health in Hawaii
- Ensure commitment to sustaining the System of Care
- Promote the use of current knowledge regarding evidence-based services in the development of individualized plans and promote the mental health system in a manner to facilitate the application of these services
- Ensure regular and routine evaluation of performance data and application of findings to guide management, programmatic and service decisions
- Ensure business practices throughout the system are accountable to populations served and funding authorities

Implementation Strategies to meet Performance Measures and status at Report date, December 2004

A management retreat, Family Guidance Center (FGC) staff meetings, Stakeholder and other community meetings were convened over the last several months to provide input on the status of CAMHD activities and strategies to assess the CAMHD performance at the two-year period of the four-year Plan.

The following summarizes the five major goals and provides an overall assessment as to where the performance measures were met, partially met or not met. Where measures were not met an explanation is provided.

There were 110 performance measures for the first two years of the Plan. The CAMHD met 65 (59%), partially met 21 (19%) and did not meet 24 (22%). 100% of the measures for adherence to evidence-based practices were met or partially met. 97% of the measures for quality and accountable business practices were met or partially met. Interim measures for shared ownership, adherence to Guiding Principles and evaluation of performance data and application of findings were met or partially met to a lesser extent.

In addition, the following reports, available on the CAMHD web site, were instrumental in evaluating the status of the performance measures at December 2004. Highlights from these reports will be included in this discussion and or referenced as noted in italics.

UCSF June '04 or External Evaluation Report 2 - Rosenblatt, A., Hilley, L., Thornton, P., (2004) Evaluation Frameworks: Hawaii Department of Public Health's Child and Adolescent Mental Health Division (CAMHD) University of California San Francisco Child Services Research Group

UCSF Oct. '03 or External Evaluation Report 1 - Rosenblatt, A., Hilley, L., Thornton, P., Frank, K., (2003) Evaluation Frameworks: Hawaii Department of Public Health's Child and Adolescent Mental Health Division (CAMHD) University of California San Francisco Child Services Research Group

MedQUEST Quality Review or External Quality Review - Health Services Advisory Group, (2004) 2004 Annual On-Site Review of Quality Assessment and Performance Improvement for CAMHD Phoenix, Arizona

Integrated Performance Monitoring Reports - Quarterly Reports, April 2003 through September 2004.

Consumer Survey Report FY03 - Daleiden, E. (2003) Consumer Survey Report Fiscal Year 2003: Year to Date Honolulu, HI, Hawaii Department of Health Child and Adolescent Mental Health Division

Annual Evaluation Report FY03 - Daleiden, E (2003) Annual Evaluation Report Fiscal Year 2003, Honolulu, HI, Hawaii Department of Health Child and Adolescent Mental Health Division

PI Recomm. Addendum to FY03 Eval. - Daleiden, E (2003) Performance Improvement Recommendations: Addendum to Annual Evaluation Report Fiscal Year 2003, Honolulu, HI, Hawaii Department of Health Child and Adolescent Mental Health Division

Evaluation System Summary - Daleiden, E. (2003) Evaluation System Summary, Honolulu, HI, Hawaii Department of Health Child and Adolescent Mental Health Division

Child Status Measurement: System Performance Improvements During Fiscal Years 2002-2004 - Daleiden, E. (2004) Child Status Measurement: System Performance Improvements During Fiscal Years 2002-2004, Honolulu, HI, Hawaii Department of Health Child and Adolescent Mental Health Division

Developing Shared Ownership (Goal 1): CAMHD will facilitate and support the shared ownership of the CAMHD vision, mission, initiatives, and achieved outcomes.

The performance measures for Goal 1 included measures for engaging other child serving agencies and cultivating internal management values through implementation of a supervisory structure. With shared ownership the performance measures would evaluate the adequacy of resources to meet statutory mandates, begin an evaluation of statutes to support all child-serving entities, increase federal funding and integrate evidence-based services into the System of Care. Shared ownership would also be evaluated by improving the active engagement of, and communication with families, community organizations and increased collaboration with Hawaii's university and community colleges.

Many youth who receive services through CAMHD are involved with other public child serving agencies including the Department of Human Services (DHS) child welfare services, Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home (DH), and the MedQUEST Division of DHS. The data table to the right demonstrates the need for strong interagency collaboration when serving youth. While a specific child may be duplicated in this count, as in Serious Emotional/Behavioral Disturbance (SEBD), DHS and the Court categories the majority of children registered with the CAMHD have interagency relationships.

Data period July 2004 to September 2004

Agency Involvement	N	%
DHS – child welfare	195	11.1%
Family Court	482	27.4%
HYCF or DH	142	8.1%
SEBD eligible	458	26.0%
Quest eligible	656	37.3%

Goal 1 Results

Of the twenty one (21) specific performance measures for Goal 1; nine (9) were met, four (4) were partially met and eight (8) were not met. **62% of the shared ownership goals were met or partially met.**

Goal 1 anticipated the establishment of a statewide leadership framework and the associated training and mentoring to assure all child-serving entities would have an understanding and appreciation of each other's roles and responsibilities. While this goal was determined met based on prior participation at the statewide level, there is no current statewide leadership framework. In the summer of 2001 the DOH via CAMHD was awarded a Substance Abuse & Mental Health Service Administration (SAMHSA) grant to form a statewide "Policy Academy". The Directors of Health and Human Services, a Family Court Judge, Legislators, providers and family members (or their designees) met from the summer of 2001 through 2003. The facilitated meetings were summarized and the information is maintained at the CAMHD. The meetings were discontinued in 2003 due to the change in leadership in the Departments of Health and Human Services. There have been no interagency children's policy meetings since that time.

Information shared by CAMHD Central Office (CO), FGC staff, family and other child serving agencies indicate shared ownership is occurring at the local community levels. CAMHD FGC's participate quarterly in interagency management meetings to address systemic problem areas in their specific districts, and the state level CAMHD administration meets with the Department of Education to discuss quality issues unique to their two agencies. It appears there has been inconsistent statewide sharing of information via minutes or informal communications back to the local communities.

There is a formal documented protocol for resolving interagency disputes; however, it is questionable how often this protocol has been used. Stakeholders reported that interagency disputes are frequently resolved at community interagency meetings. Feedback also suggested that if a dispute cannot be resolved at the branch level the dispute is referred to the Division Chief. Feedback suggested that case-by-case resolution appears to be occurring.

To accomplish the goals of shared accountability, the child serving agencies were expected to have worked toward developing an integrated system of care that would allow children and youth to grow into healthy, successful and productive adults. Shared accountability would have been evaluated by joint presentations, training and mentoring. There have been no joint presentations, training or mentoring of interagency framework to community Stakeholders.

The Plan committed the CAMHD to maximizing federal and other funding opportunities and to work with other child serving agencies to create full-time grant writer positions. There has been no targeted interagency effort toward maximizing federal grant funding. However, recent efforts between DHS and CAMHD, has focused on increasing federal Medicaid and Title IV-E funding. A full-time grant writer was not hired by the CAMHD. No information is available to determine if other child serving agencies have hired full-time grant writers.

The CAMHD has continued a supervisory structure that includes the supervision of each branch chief by the Division Chief on a monthly basis. Supervision at the FGC is done monthly both at an individual and group basis, including the FGC clinical directors. Specific tools and documentation are used and maintained. Monthly case presentations at the FGC focus on youth exceeding length of stay and other outlier characteristics. CAMHD employees have a current performance appraisal summary (PAS) and individual supervision plans.

Goal 1 included a performance measure to increase the amount of QUEST reimbursements. While the specific measure was not met, effective with a memorandum of agreement dated May 28, 2004 for July 1, 2003 to June 30, 2004 (extended to June 30, 2005) between the MedQUEST Division of the Department of Human Services and the CAMHD the CAMHD became a health plan to provide behavioral services for QUEST and Medicaid Fee-For-Service children and adolescents who are SEBD and in need of intensive mental health services. The memorandum provides for a reimbursement of services not to exceed $7.5 million in Federal funds per fiscal year.

CAMHD has evaluated the relevant statutory language, as currently written, with the DOH Director and the Department of the Attorney General. No statutory changes were proposed to the Legislature during the 2003 or 2004 sessions and they will not be submitted during the upcoming 2005 session.

The CAMHD applied for and recently received two multi-years grants. The funds have been provided by the Substance Abuse Mental Health Services Administration (SAMHSA) and support training to reduce use of seclusion and restraint in treatment programs and data infrastructure development to enhance performance monitoring activities.

The initiative to develop shared ownership also includes the children/youth and families served by the system. Families and community organizations must feel that they are a part of the process, and that the State is working with them, and not leading them. There have been continued improvements in the communications with families. The registration process at the FGCs has been modified to include review of the role of the Parent Partner (employee of contracted provider providing family support, see discussion later) and obtain consent for the Parent Partner to contact the family for support. The Experience of Care and Health Outcomes (ECHO™) survey, a mail and phone survey completed by caregivers, showed:

- Over 80% report favorably regarding their counseling and treatment
- Over 75% report favorably regarding CAMHD as a company managing benefits

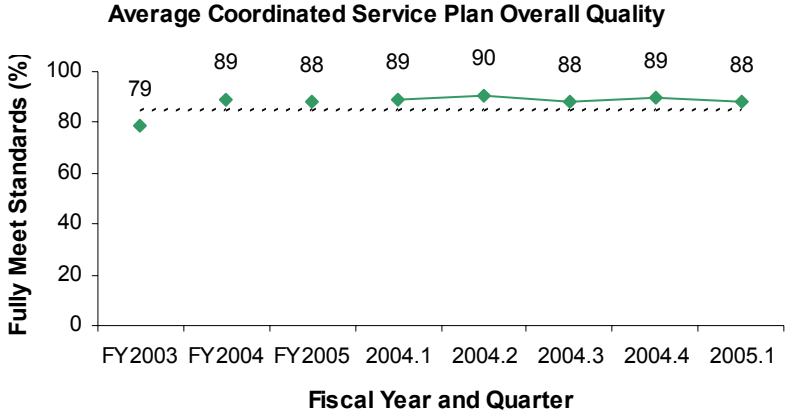
A more detailed discussion of the survey and its benefits is included under the Goal 3 discussion.

The performance measures for Goal 1 included specific measures designed to evaluate the mental health labor force and increase the collaboration with Hawaii's university and community colleges in training students in Guiding Principles (Hawaii CASSP) and evidence-based services. Through the CAMHD Credentialing Committee process, CAMHD has some awareness of which programs are producing the children's mental health labor force. Clinical leadership has met with these local universities and colleges and participated in some classroom discussions, as well as supervised trainees. No mini-modules, as suggested in the Plan, have been specifically included in curricula.

Maintaining adherence to Guiding Principles (Hawaii CASSP) (Goal 2): The CAMHD and its providers will consistently adhere to the Guiding Principles (Hawaii CASSP).

The performance measures for Goal 2 included the continued education and training to inform CAMHD Stakeholders to understand the populations served and the context of the Guiding Principles (Hawaii CASSP) and how to utilize them to steer treatment decisions. Information gained in the consumer surveys was to be used to integrate the Guiding Principles (Hawaii CASSP) into the supervision of care coordination. To address the need for consistent and accessible information on the resources available in each community, the FGC Branch Chiefs, CAMHD Managers, and Hawaii Families as Allies (HFAA: a contracted family support organization) were to provide catalogues of formal and informal resources/supports currently available in the communities and through partner agencies/entities. To assure training and coordination across specific populations a separate strategic plan was to be developed to address the full continuum of mental health services for youth involved in the juvenile justice system and CAMHD staff were to participate in the review and revision of the state's Juvenile Sex Offender (JSO) Master Plan. The CAMHD was to lead and participate in ongoing efforts to reduce the stigma of mental illness and improve understanding and acceptance of families of children/youth with mental illness. Goal 2 embraced continued training and mentoring to assure staff and HFAA will support youth in the planning process and in their home environments. To address public health needs the CAMHD was to continue the use of federal Community Mental Health Services Block Grant (Block Grant) funding to support the homeless, transgender youth and for early-intervention services.

Training, mentoring and family engagement in accordance with Guiding Principles (Hawaii CASSP) through the Coordinated Service Plan (CSP) process is evaluated in the quarterly Integrated Performance Monitoring Reports. The statewide data for quality of CSPs are displayed to the right:



Goal 2 Results

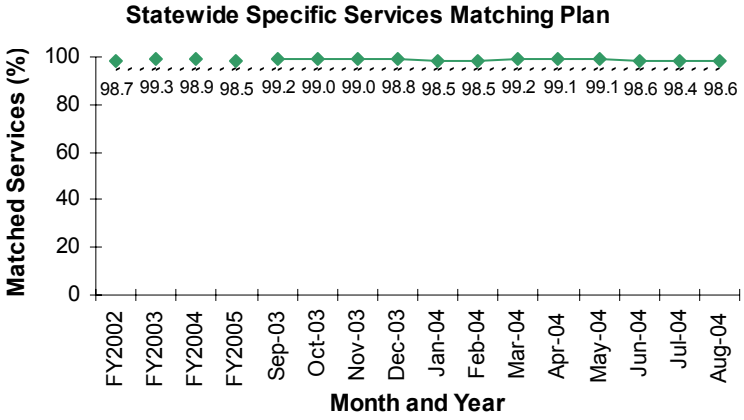
Of the twenty-eight (28) specific performance measures for the Goal 2; fourteen (14) were met, five (5) were partially met and nine (9) were not met. **68% of the goals related to adherence to Guiding Principles (Hawaii CASSP) principles were met or partially met.**

Of the twenty-eight measures, ten measures were designed to evaluate the CAMHD's ability to create a community-based, accessible System of Care through which families are guided by knowledgeable and experienced staff. All of these ten measures were met or partially met. This is reflected in the continued improvement of coordinated service plan overall quality measures and was also evident in widespread feedback across FGCs and Stakeholders involved with and knowledgeable about the System of Care. The contract with the family organization HFAA was recently modified to increase the focus on statewide policy support and family advocacy. This modification was the result of feedback from families and the family organization to increase the communication with and to families.

A Branch Chief position was defined as identified in the Plan to address the continuum of mental health services for youth involved in the juvenile justice system. The Mental Health/Juvenile Justice (MH/JJ) strategic plan specifically developed to address the needs of the juvenile justice population is being implemented. The Branch Chief of the Family Court Liaison Branch (FCLB) is an active member of the State's sex offender treatment team (SOTT). She also routinely works with the judiciary and other child serving agencies to assure timely service provision to this population.

The performance measures tied to the "ongoing education and public relations efforts" of Goal 2 were developed anticipating a position would be created for a Media Specialist. The position was not funded or created. The CAMHD continues to widely distribute the bookmark with CAMHD Guiding Principles (Hawaii CASSP) information. Similarly additional resources were not available for peer education/mentoring/tutoring and partnerships with community organizations.

Broad community involvement and development of resources is also evaluated by performance measures evaluated by the number of youth receiving the specific treatment services identified by their service teams.



The CAMHD continues to use their allocated portion of the Block Grant funding to support children and youth whose needs are not met in traditional educational and community settings, including the homeless and at risk youth in need of mentoring. In addition Block Grant funds were used to provide consultation and technical assistance to pre-schools through a memorandum of agreement with the Early Intervention Section of the DOH, "Project Coach".

Consistently applying the current knowledge of evidence-based services in the development of treatment plans (Goal 3): The CAMHD and its provider agencies will consistently apply the current knowledge of evidence-based services in the development of individualized plans. The design of the mental health system will facilitate the application of these services.

"CAMHD seems to have progressed through the "early adopter phase" and now needs to maintain enthusiasm, interest, and daily integration of evidence-based services." PI Recomm. Addendum to FY03 Eval.

A significant performance measure of Goal 3 is to evaluate the implementation of evidence-based services into the System of Care and to continue to update and keep current the understanding of what services are empirically supported. The Evidence Based Services (EBS) Committee issued its first biennial report in the Fall of 2002. The second biennial report is expected to be released in December 2004. The CAMHD has continued developing and disseminating tools for evidence-based decision making. Training continues in the use of the tools and monitoring of treatment and most importantly child progress. The Clinical Report Module (CRM) was developed and "dashboards" (customizable screens for MHCC (Mental Health Care Coordinator) to track changing treatment issues were created. Both are in varied use on a statewide basis.

There continues to be periodic turnover in the "evidence-based" trainers. Training, implementation and evaluation are dependent on a few key individuals**.** The Clinical Director and chair of the EBS Committee returned to the University of Hawaii full-time in June 2003. He continues to provide consultation to the CAMHD on a very limited contract basis. The CAMHD Medical Director serves in a dual capacity as Medical Director and Clinical Director.

Goal 3 Results

Of the thirteen (13) specific performance measures for the Goal 3; six (6) were met, one (1) was partially met and six (6) were not met. **54% of the performance measures related to adherence to evidence-based practices were met or partially met**.

"Service planning and clinical care involve an extremely diverse and often poorly specified decision-making space. The development of practice guidelines and evidence-based services reviews are a good example of efforts to clarify decision making." Evaluation System Summary

Goal 3 and the related performance measures were developed to evaluate the application of evidence-based services in individual treatment plans. Application by MHCC and providers follows the implementation strategies and their success or failure as identified in Goal 1. Goal 3 performance measures begin by evaluating the training of CAMHD staff and providers. Training includes the use of evidence-based curricula and fact sheets for use by individual teams. Following dissemination and training, performance measures evaluate the mechanisms for the ongoing evaluation of the use and effectiveness of evidence-based services. The final measure of the use of evidence-based services is the system's ability to sustain these efforts.

Training syllabi and attendance records document the training provided to CAMHD staff and providers in evidence-based services. Individual supervision plans also document training needs identified and provided. The MHCC care coordination supervision model was developed and

FY03	100% of the Mental Health Supervisors have received training on the use of it. A provider supervision model has not been developed. Evidence-based service menus (blue cards) are available and appear to be in widespread use across the state based on feedback of staff and providers.
"The use of evidence-based practices remains a strong characteristic of CAMHD and significantly influences the characteristics of the current evaluation system". UCSF Oct. '03 or External Evaluation Report 1	Training in evidence-based decision-making has been provided to FGC leadership. The Research and Evaluation Specialist (RES) developed a power point presentation of the external system evaluation Evaluation Frameworks: Hawaii Department of Public Health's Child and Adolescent Mental Health Division (CAMHD), University of California San Francisco Child Services Research Group, for presentation to FGC staff and providers. The RES presented "Treatment Programs & Treatment Systems: Evidence-Based Services in Context at the 2004 National Training Institutes on "Developing Local Systems of Care for Children and Adolescents with Emotional Disturbances and their Families: Early Intervention" San Francisco, CA June 2004. This presentation has also been provided across the state to FGC staff and providers.

In the spring of 2004, CAMHD initiated its annual administration of the Experience of Care and Health Outcomes (ECHO™) survey to assess family satisfaction. The survey was selected because it builds on widely used instruments for behavioral health care quality assessment, and was designed with the unique needs of populations similar to that served by CAMHD. It assesses consumer experiences with a number of aspects of care including quick access to care, communication with clinicians, information provided by clinicians, consumer involvement in treatment, information about treatment options, and the behavioral health organization's administrative services. The survey collects useful information about the characteristics of youth and their families. Another advantage of using the ECHO™ survey is that it allows for comparison of CAMHD results with other children's mental health delivery systems. Each fall, data from the behavioral health plans across the country that use the ECHO™ are released, and CAMHD will be able to use this information to further refine its performance.

The EBS Committee consisting of CAMHD leadership, academia, providers and families regularly met to continue to review and evaluate the relevant research to inform service delivery and practice development within CAMHD. Their review and recommendations provide the knowledge to guide the practice of evidence-based services. During the first two years of the Plan the EBS Committee screened more than 300 articles per quarter, coding of an average of 28 items per quarter (articles or protocols), across an average of 4.75 topic areas. Coding delineates the specifics of the research such as age, gender, ethnicity, and diagnostic category. Topic areas include but are not limited to autism, anorexia, and co-occurring disorders. Prior to the Plan the coding process was time intensive and due to the technical nature performed by a limited number of EBS Committee members. Innovations over the past two years include a new coding strategy and accompanying codebook for psychopharmacology research, redesign of the psychosocial treatment coding strategy and the implementation of a new coding initiative to identify common elements of evidence-based protocols. For sustainability purposes, the Committee Chair fully automated the performance measure data collection system and redesigned all the performance measures and rewrote their definitions. The RES is in the process of transferring the initial core data from the

previous database to a custom-designed system. The transfer was approximately 90% complete as of November 1, 2004. This new system is designed to provide enhanced accessibility for EBS data retrieval and wider flexibility for rapid reporting and data evaluation related to practice policy. These efforts will also provide for sustainability of the EBS Committees efforts.

Evaluation of performance data and application of findings (Goal 4): CAMHD and its provider agencies routinely evaluate performance data and apply the findings to guide management decisions and practice development.

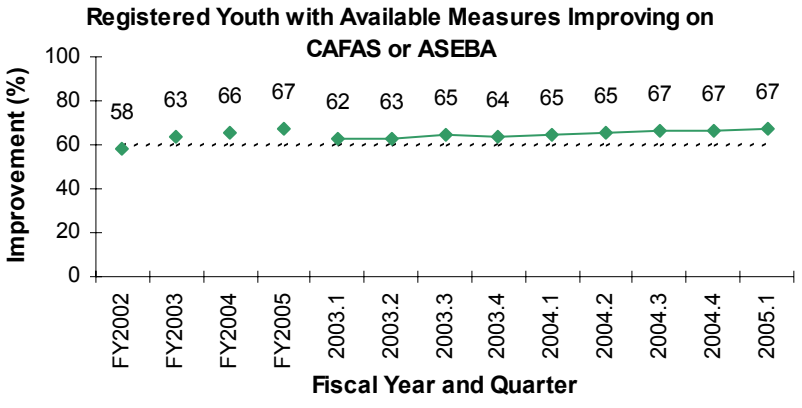
The performance measures of Goal 4 build further on the previous three goals by expanding and improving operational evaluation and supervision systems to provide timely information that is clinically relevant and regularly exchanged in collaborative partnerships. User-friendly reports and studies of the System of Care would be provided to professional, legislative and family groups in such a way as to incorporate feedback in system design. Performance measures were designed to evaluate the completion of methodology binder. The methodology binders would assure consistent definitions were used in evaluating the performance measures.

Goal 4 Results

Of the fifteen (15) specific performance measures for the Goal 4; eleven (11) were met, four (4) were partially met. **100% of the performance goals related to evaluation of performance data and application of findings were met or partially met.**

The CRM, also known as the "dashboards," was developed to provide comprehensive caseload summaries and individual client histories on an "on demand" basis across the State. To evaluate the supervision of the system the Plan provided a performance measure the percentage of youth with a current CSP and the percentage compliance with CSP quality indicators (information provided in Goal 2 discussion). In addition the system is evaluated on improved outcomes of child status indicators.

"In sum, the CAMHD service system appears to effectively help the majority of youth with intensive mental health problems return to better functioning...(Annual Evaluation Report FY03)



First and foremost the CAMHD is committed to improving the lives of children and families. Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA) are standardized tools used to assist families and treatment teams measure individual child improvement.

CAMHD recently examined the rate of child improvements over time through a study entitled, "Child Status Measurement: System Performance Improvements During Fiscal Years 2002-2004." Analyses were conducted across measures of functioning, service needs, and symptomatology.

At the end of the study, youth were improving significantly more rapidly than at the beginning of the study. This finding of significant improvement was consistent across all adult (parent, teacher, and clinician) reported measures of child status but not on the youth self report ASEBA, which demonstrated consistent but not significant improvement rates throughout the study period.

These improvements in child status coincided with the successful implementation of CAMHD initiatives including; dissemination of evidence-based practices, development of care coordination practice, increased information feedback to stakeholders, improved utilization management, adoption of the use of performance measures statewide, the restructuring of quality improvement operations, and the integration of practice-focused performance management at the various levels of the service system. This data presents some of the most compelling information to date regarding the impact of the mental health service system improvements on the health outcomes for youth served.

The Interagency Performance Monitoring Reports provide a quarterly summary of system performance measures. The Annual Evaluation Report Fiscal Year 2003 analyzes the findings and describes the development of changes to the CAMHD from July 1, 2000 to June 30, 2003. CAMHD gathers a wide variety of information about the performance of its operations. This information may be summarized into five major categories. First, population information is collected to understand the characteristics of the children, youth, and families that are served. Second, service information is compiled regarding the type and amount of direct care services used by children, youth, and families. Third, financial information is gathered about the cost of services. Fourth, system information is collected about the quality and operations of the statewide infrastructure needed to support children, youth, and families. Finally, outcome information is examined to determine the extent to which services provided lead to improvements in the functioning and satisfaction of children, youth, and families.

The Evaluation System Summary FY03 evaluated the CAMHD system; its population, services, fiscal resources, outcome and systems operations. The evaluation was done in terms of four key domains; infrastructure, information capture, analysis and reporting and knowledge application and decision-making.

Quality monitoring reviews that include case-based reviews and administrative reviews continue using the case-based review methodology developed by Human Systems and Outcomes. The CAMHD participates in interagency monitoring with the Department of Education and intra-agency monitoring with the Developmental Disabilities Division and Early Intervention Section of the DOH.

The performance measure for development and distribution of user-friendly reports and studies of the System of Care would be provided to professional, legislative and family groups in such a way as to incorporate feedback in system design was met to the extent numerous reports as excerpted for this report are available on the CAMHD web site. The performance measure anticipated the creation and funding of a Media Specialist for wider distribution; the position was not created or funded.

The CAMHD Chief, Performance Manager, Medical Director and the Research and Evaluation Specialist have presented at national conferences. The CAMHD Chief, Research and Evaluation Specialist, and Chair of the EBS Committee have published articles.

Quality and Accountable Business Practices (Goal 5): The business practices implemented throughout CAMHD and its provider agencies ensure high quality and accountable operations.

The performance measures for Goal 5 were developed to evaluate the CAMHD staffs' understanding of their roles and responsibilities. Performance measures were developed to ensure good business practice, system accountability and to assure technology development was available to support all of the performance measures of the Plan.

Goal 5 Results

Of the thirty-three (33) specific performance measures for the Goal 4; twenty-five (25) were met, seven (7) were partially met and one (1) was not met. **97% of the performance goals related to quality and accountable business practices met or partially met.**

The Contracts and Fiscal Management sections have completed a workflow analysis. Staffing plans have been discussed and will be submitted as part of a formal DOH re-organization plan.

The CAMHD has met the confidentiality, privacy, and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). In-service training programs have had limited development, concentrating primarily on the needs of HIPAA and MedQUEST compliance.

"Preliminary analysis of factors predicting change revealed that hospital residential, therapeutic group home, and multisystemic therapy provide the setting most associated with reliable improvements, whereas intensive in-home services were most associated with maintaining stability."
Annual Evaluation Report FY03

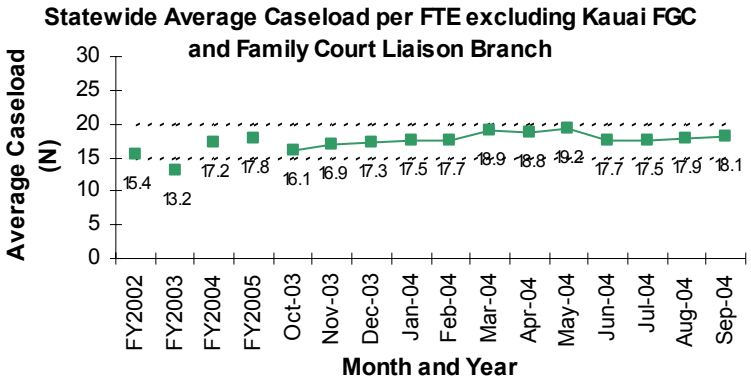
The Utilization Management Plan has established thresholds for review of resource utilization on a daily basis through and including analysis in the Annual Evaluation Report. The performance measure was composed of three measures: decrease in number of and length of stay (LOS) for mainland placements (met), decrease in number of and LOS for hospital-based residential (met) and decrease in number and LOS for out-of home placement (not met). From the Annual Evaluation Report "Despite the general population decline, community high-risk residential and multisystemic therapy displayed both absolute and relative growth, community residential services also demonstrated both absolute and relative growth, but a small decline in monthly average suggested that more youth may be using this level of care for shorter durations. Therapeutic group homes, therapeutic foster homes, intensive in-home, and flex services accounted for an increasing proportion of services over the study period, but demonstrated a lower absolute size. Hospital residential services displayed an absolute decrease in size and average census but accounted for a relatively stable proportion of the service population, suggesting that placements rates have not decreased within the CAMHD system beyond the general population decline, but length of service has decreased considerably. Out-of-state, partial hospitalization, day treatment, respite and less intensive services displayed both absolute and relative decreases over the three-year study period".

The CAMHD developed a treatment services report (Summary of Services) from the information and billing systems that summarizes, on a monthly basis, the treatment services provided to an individual child/youth. The Summary of Services is made available to the MHCC for treatment team planning and

family discussions. The CAMHD mails the monthly Summary of Services to families. The Summary of Services includes a statement to contact your child's MHCC if you have any questions or concerns about the services provided. MHCC, in treatment notes, are to document that they talked with the family about the Summary of Services.

The CAMHD defined the requirements to automate CAMHD's accounting function to interface with the Department of Accounting and General Services. With this information the CAMHD concluded no further changes were required.

The CAMHD continues to analyze MHCC caseloads and staffing to meet geographic need. CAMHD expects that MHCC caseloads will consistently fall in the range of 15 to 20 youth per full time MHCC in order to provide quality intensive case management services.



A performance measure was set for each FGC and operating section (clinical, fiscal and performance) to operate within their budget. Specific internal budgets have not been completed by section. On an overall basis the CAMHD functioned within its budget. The following provides general fund expenditures for fiscal years 2003, 2004 and the general fund budget for fiscal year 2005.

	FY '03 EXPENDITURES	FY '04 EXPENDITURES	FY '05 BUDGETED
Family Guidance Centers	$ 8,855,329	$ 7,709,781	$ 7,573,604
Central Office	4,401,551	3,514,331	4,054,445
POS Services	45,189,515	42,888,460	44,064,372
TOTAL	$58,446,395	$54,112,572	$55,692,421

The performance measures for the implementation of the information management systems were met. The majority of these improvements: CRM, HIPAA and web site were previously discussed.

Hawaii in context of changes in Children's Mental Health

Subsequent to the publication of the CAMHD four-year strategic plan there has been significant contributions by national and state leadership. These reports, studies and presentations and their impact on the Plan warrant discussion in this report.

"Mental illnesses are shockingly common; they affect almost every American family. It can happen to a child, a brother, a grandparent…It can happen to someone from any background-African American, Alaska Native…No community is unaffected by mental illness; no school or workplace is untouched
(Executive Summary, New Freedom Commission on Mental Health)

The President's New Freedom Commission on Mental Health issued their report entitled "Achieving the Promise: Transforming Mental Health Care in America" in July 2003. The President charged the Commission with studying the mental health system and to make recommendations that would enable adults with serious mental illness and children with serious emotional disturbance to live, work, and participate fully in their communities. The Commission concluded "Today's mental health system is a patchwork relic-the result of disjointed reforms and polices. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities".

The report identified six major goals for a transformed mental health system.

- Americans understand that mental health is essential to overall health.
- Mental health care is consumer and family driven.
- Disparities in mental health services are eliminated.
- Early mental health screening, assessment, and referral to services are common practice.
- Excellent mental health care is delivered and research is accelerated.
- Technology is used to access mental health care and information.

From the New Freedom Commission Report, the SAMHSA issued its' report "A Life in the Community for Everyone Building Resilience and Facilitating Recovery. The report identified eleven programs/issues and the inter relationship with ten crosscutting principles.

Hawaii – As evidenced by this interim report the children's mental health system in Hawaii has created a System of Care and is well on its way to meeting many of the goals outlined in the New Freedom report. Borrowing from SAMHSA's format the following illustrates those areas where the children's mental health system is making progress and areas for continued focus. The Director of Health has issued a call to assure that all DOH programs are aligned with the Core Functions of Public Health (Institute of Medicine, 1988); assessment, policy development and assurance. And, those individual program goals align with the ten essential public health services.

With the New Freedom Commission Report, SAMHSA Priorities and Department of Health leadership the CAMHD will align its goals, performance measure and programs to meet the its mission "to provide timely and effective mental health services to children and youth with emotional and behavioral challenges, and their families".

Next Steps

The Performance Improvement Recommendations: Addendum to Annual Evaluation Report FY2003 provides recommendations based on discussions following the publication and presentation of the Annual Evaluation Report for Fiscal Year 2003. As noted, "careful selection of key initiatives and implementation of well-defined improvement programs with sufficient dosage was recommended".

The report contains recommendations for evaluating ways to improve the quality and services provided by CAMHD. The recommendations are summarized as:

Population Decline and Availability of Services – Understanding and extending the reach of the referral process and continued development of partnerships with the juvenile justice system.

- Understand and communicate CAMHD product lines – standardize definitions and market services
- Identify and address barriers to assessment and enrollment – focus on outreach and facilitating access to public services
- Improve community outreach – target key populations and engage at their access points
- Transitions – strengthen interagency quality assurance and engage the provider network to identify barriers and solutions

Utilization of Out-of-Home Services

- Provide concrete guidance for level of care decision making
- Involve out-of-home providers in decision making criteria to develop shared ownership of "no rejections or ejections"
- Emphasize parent responsibility and treatment – strengthen parents and families, continue to develop a strong parent partner organization
- Focus on prevention – identify youth before they need more intensive care
- Target conduct problems – monitoring and promotion of increased referrals to Multisystemic Therapy (MST)

Child Status

- Early identification and treatment to avoid more intensive and costly services
- Understand child improvements – continue to develop a system to evaluate and understand what works best for CAMHD youth

Quality Improvement Processes

- Change structure of Performance Improvement Steering Committee – more of the implications of data and less on data presentation
- Develop local quality processes - disseminate statewide performance and promote feedback for statewide solutions
- Evidence-based services – continue development and dissemination

In addition specific additional gap groups or services were identified in the information gathering for this report that may supplement the above recommendations. These gap groups and services include: establishing relationships with law enforcement to address "run-aways and fire-starters"; assuming responsibility (financial and capacity) for developing provider capacity; and developing a research plan (identify what to study and potential partnerships).

Specific discussions of "culturally sensitive" as stated in #1 of the Guiding Principles (Hawaii CASSP) are embedded in many of the principles and performance measures. The commitment to developing an array of services that are culturally appropriate and clinicians that are culturally competent prompted an additional focus group to evaluate "cultural competency" as it relates overall to the performance measures. The focus group recommendations are summarized as:

- Develop a system definition of "culture" and develop a Conduct/Cultural Code of Ethics
- Engage community based groups to perform a cultural assessment
- Integrate culture competency into EBS, training, provider evaluation, staff training and evaluation
- Establish a Cultural Competency Review Committee

During the first two years of the Plan the U.S. Department of Justice (DOJ) found the CAMHD in compliance with the terms of the 1991 Settlement Agreement Child and Adolescent Residential Services (Settlement Agreement). In the spring of 2003 the State of Hawaii and the DOJ entered into a joint stipulation that deemed CAMHD in full compliance with provisions of the Settlement Agreement that was in effect since the early 1990's. The action represents agreement by the DOJ to partially dismiss the State from the Settlement Agreement that sought compliance of the Hawaii State Hospital with provisions of the Civil Rights of Institutionalized Persons Act (CRIPA). With the filing of the joint stipulation the DOJ has agreed that CAMHD and its hospital based residential programs have not only met the terms of the Settlement Agreement, but have demonstrated the capacity to provide ongoing monitoring and oversight in support of the population of youth who need hospitalization. Over the years, the CAMHD has clearly shown the DOJ that it can monitor all programs and serve the vast majority of youth appropriately in community-based settings.

December 31, 2003 marked the end of the 18-month "sustainability phase" of the Felix Consent Decree. The Federal Court accepted a Stipulation for Step-Down and Termination of the Revised Consent Decree. The stipulations agreed to by the parties provide the federal court with assurance sufficient funding for sustainability will continue through the State's next biennium budget. The Federal Court's acceptance of the Stipulation for Step-Down and Termination of the Revised Consent Decree opens a new era in the provision of services to students in need of educational and mental health services.

"While we continue our work to enhance the System of Care for Hawaii's children, we must give focus to the above recommendations while not losing sight of the commitment to advocate for the cross agency integrated planning for children's behavioral health, to include services, systems, and funding mechanisms. We shall challenge ourselves to keep focus on the careful dissemination of evidence-based services across our System of Care that values individualized planning and cultural competency. In doing so we will continue to focus on the core value of monitoring and evaluation, as it will be used to continue guiding the system. Lastly, through this process we will maintain good business practices and fiscal responsibility to build and maintain the confidence of Stakeholders.

I would like to personally thank those who participated in this evaluation and their ongoing work to support the Child and Adolescent Mental Health Division."

Closing comments from the Chief, Christina Donkervoet

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Implementation Strategy	Performance Measure	Status Report at December 2004
Goal 1: CAMHD has a responsibility to facilitate and support the shared ownership of the CAMHD vision mission, initiatives, and achieved outcomes.		
1.1 *All child serving entities have a clear understanding and appreciation of each other's roles and responsibilities in addition to their own:*		
• Development of a statewide leadership framework.	• Establishment of a statewide leadership framework.	• Met (partial). A statewide "Policy Academy", met from the summer of 2001 through March 2003. The meetings were discontinued in 2003 due to the change in leadership in the Departments of Health and Human Services.
• Implementation of the statewide leadership framework at the community and local level, through visits and discussions with community stakeholders throughout the state.	• Training and mentoring completed and interagency framework jointly presented to community stakeholders.	• Met (partial). There is no statewide leadership framework. CAMHD FGCs participate quarterly in interagency management meetings to address systemic problem areas in their specific districts, and the state level CAMHD administration meets with the Department of Education to discuss quality issues unique to their two agencies.
• Facilitation of an agreement upon joint outcome measures among members of the leadership framework.	• Joint outcome measures agreed upon.	• Not met.
• Facilitation of the establishment of baseline protocol for resolving interagency disputes and then modifies to be responsive to each community's characteristics.	• Protocols are developed and implemented at the state and community level.	• Not met.

• Cultivation and improvement of the CAMHD internal management values and practices through:
  • Appropriate supervisory infrastructure.
  • Regular opportunities for feedback on work environment.
  • Integration of management values into everyday operations.
	• All CAMHD employees receiving consistent supervision and regular opportunity for feedback. All CAMHD employees embrace equal ownership for the system's accomplishments, challenges, and shortcomings.	• **Met.** Supervision and feed back is ongoing. MHCC have individual supervision plans and participate in individual and group supervision on a monthly basis. The Division Chief provides monthly supervision to all Branch Chiefs. Employees have a current performance appraisal summary (PAS) and individual supervision plans. The CAMHD employee handbook was revised. Orientation is provided to new employees.

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Implementation Strategy	Performance Measure	Status Report at December 2004
1.2 *There will be adequate resources available for all child serving entities in order to meet their statutory mandates and their obligation to Hawaii's children and youth.*		
• Implementation of a CAMHD State Plan Amendment (MedQUEST funding) that includes a commitment to evidence-based services.	• Increase in amount of MedQUEST reimbursements received.	• Not met. No increase in MedQUEST reimbursements.
• Begin to look at updating CAMHD statutes and also support the update of all child serving entity statutes.	• Statutory updates begun.	• Not met. No statutory changes were proposed to the Legislature during the 2003 or 2004 sessions and they will not be submitted during the upcoming 2005 session. The Planner position became vacant in January 2003. In October 2004 CAMHD received approval for internal recruitment.
• Support the completion of statutory updates for all child serving entities in the state.	• All statutes are updated.	• Not met.
• Maximization of federal grant funding opportunities:	• Increase in amount of federal funding opportunities received.	• **Met.** SAMHSA $150,000/yr. Data Infrastructure Grant (3 yr.), $250,000/yr. Training Grant to reduce seclusion and restraint (3 yr.)
◦ All agencies should have approved, and then hire, a full-time grant writer.	• Full time grant writer hired for every child serving entity.	• Not met. No grant writer hired for CAMHD. Grants submitted with contracted assistance. Information is not available to assess if a full-time grant writer was hired in any other child serving agency.
◦ Overall training and education on researching grant opportunities and grant writing.	• Training and education completed.	• Not met. No specific training.
• Continue to maximize federal grant and other reimbursement opportunities.	• Increase in percentage of overall resources available to CAMHD that are obtained through federal grant and similar funding opportunities.	• **Met.** Funding received on multi year grants.
• Integration of EBS into the system of care.	• EBS are available statewide, can be evaluated, and implementation and evaluation is sustainable.	• Met (partial). EBS are available to the extent of the dissemination of training and availability of resources. MST is available state-wide. Training, implementation and evaluation are dependent on a few key individuals. The Clinical Director and chair

Implementation Strategy	Performance Measure	Status Report at December 2004
		of the EBS Committee returned to the University of Hawaii full-time in June 2003.
• Continue to update and keep current our understanding of what services are empirically supported.	• The integration of evidence-based services continues, and the system understands of what services are evidence-based, is current and continues to be revised according to current research.	• Met (partial). While activities continued there are no ongoing efforts to integrate into interagency systems of care.
1.3 *Improvement in the active engagement of, and communication with, families and community organizations invested in the system of care:*		
• Provide each family entering into and already in the system, an informational packet and orientation on HFAA parent partners and services provided, to also include CCC flyer.	• All new and current families are given this information. Increase in referrals to and utilization of Parent Partners.	• **Met.** HFAA provides brochures. The consent form was modified to include language that a Parent Partner would contact the family, unless the family objects. Number of referrals is not maintained.
• Encourage MHCCs to include informal contacts in their engagement with families.	• MHCCs have begun to engage with families through informal contacts.	• **Met.** MHCC engagement is monitored through individual and group supervision.

• Increase public awareness of the system's accomplishments.
  • Newsletter
  • Television Ads/Public Service Announcements
  • Public "Thank You's"
	• Increase in family satisfaction and true participation in the process, as measured by revised Family Satisfaction Surveys.	• **Met.** ECHO report shows over 80% report favorably regarding their counseling and treatment

1.4 *Increased collaboration with Hawaii's university and community college institutions in training students in CASSP principles, EBS, and an evaluative manner of thinking.*		
• Map out where the children's mental health labor force comes from/out of which disciplines.	• Mapping completed.	• **Met.** Informal discussions of labor force.
• Facilitate meetings/discussions with university and community college educators on how CAMHD can	• At least 2 meetings have been held with identified CAMHD staff and	• **Met**. Clinical leadership has met more than two times with university and community college

Implementation Strategy	Performance Measure	Status Report at December 2004
help them include these values/practices in their curricula. • Develop mini-modules that can be included in the curricula. • Offer to guest lecture in classrooms.	university and community college educators. • Mini-modules covering different practice areas developed. • Offers to guest lecture are made.	educators. • Not met. • **Met.** Clinical leadership has offered and participated in classrooms.
Goal 2: The CAMHD and its providers will consistently adhere to the Hawaii CASSP principles. **2.1** *Create a community-based, accessible System of Care through which families are guided by knowledgeable and experienced veteran staff.* • Educate, train and inform CAMHD stakeholders and families to understand populations served by CAMHD and the context of CASSP. • Research catalogues of formal and informal resources/supports currently available in the communities and through partner agencies/entities. • Train all CAMHD staff to know and understand populations served and context of CASSP principles. • Provide teaching tools including examples of populations served and application of CASSP. • Collect information on consumer satisfaction with the system, inclusive of CAMHD, regarding implementation of CASSP principles. • Continued integration of CASSP principles into supervision of care coordination.	• Occurs at 100% of FGC community presentations. • Hard copies of catalogues made available in each FGC, for each PP, and for HFAA. • 85%/90% of staff receives information; 85%/90 trained; 100% of attendance documented. • Data collected quarterly; annual report development begun. • Integration is continued.	• **Met.** FGC Chiefs and staff report discussions occurring at the community level. Listing of community presentations and training participants are available. • **Met.** Documents purchased and distributed to FGCs. • **Met.** Substantially met requirements of both year 1 and year 2. Training and supervision records available. • **Met.** Consumer Survey Report FY03, Integrated Performance Monitoring Reports • **Met.** Included in requirements for MHCC to collect and analyze child specific data. Development of the Clinical Reporting Module (CRM).

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Implementation Strategy	Performance Measure	Status Report at December 2004
• Strategic Plan will be developed to address full continuum of mental health services for youth involved in the juvenile justice system, inclusive of expanding the leadership role of the Family Court Liaison Branch.	• Strategic Plan to address youth involved with the juvenile justice system is developed.	• **Met.** Complete.
• Coordinate the review and revision of the state's Juvenile Sex Offender (JSO) master plan.	• Review and revision completed.	• **Met.** Revisions coordinated and submitted to Sex Offender Treatment Team
• Expand HFAA/PP role at each FGC and across stakeholder lines to guide families.	• 75% of PP positions filled; 100% of families made aware of the availability of their PP at intake.	• Met (partial). % of PP positions filled not consistently met. Contract was modified in August 2004 to increase the focus on statewide policy support and family advocacy. In January 2004 the consent forms were modified to indicate a PP will contact the family, unless family notes otherwise.
• Develop statewide resource catalogue by geographic areas. • Implementation of the Strategic Plan developed in Year 1 to address full continuum of mental health services for youth involved in the juvenile justice system.	• 50 complete. • All youth in the juvenile justice system receiving needed mental health services.	• Met (partial). FGC tailoring to individual communities. • Met (partial). To the extent youth are known to the CAMHD services are provided at HYCF and the Detention Home. No interagency agreements have been prepared to address youth not known to CAMHD.
2.2 *Ongoing education and public relations effort to broaden and improve attitudes, understanding and acceptance of families of children/youth with mental health needs.* • Research existing CASSP related materials/literature that is family friendly.	• Comprehensive list of CASSP-related materials that are family-friendly is developed.	• Met (partial). CAMHD developed and distributes bookmarks with Guiding Principles (Hawaii CASSP) information. Central, Hawaii and Maui FGCs prepare periodic newsletters to distribute information.
• Develop family/public friendly literature, which includes behavioral/functional examples for each CASSP principle, and insure focus group input.	• Brochures are developed w/minimum of one community group input per FGC.	• Not met.
• Integration of public stakeholders' logos on the Hawaii CASSP principle bookmarks.	• Logos are integrated on brochure and there is a distribution plan.	• Not met.

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Implementation Strategy	Performance Measure	Status Report at December 2004
• Develop newsletter highlighting family success stories as a method of positive public relations.	• Is published quarterly and there is a distribution plan.	• Not met.
• Co-training with FGC staff and HFAA on de-stigmatizing children's mental health, CASSP and related topics.	• 1/2 co-training scheduled and conducted for each FGC; Flyers advertising training for each FGC; 100% development of training curriculum and agendas for each topic.	• **Met.** Substantially met requirements of both year 1 and year 2. Training and supervision records available.
• Distribution of family/public friendly literature which includes behavioral/functional examples for each CASSP principle.	• Brochure printed; 90%/100% distribution to all individuals listed in distribution plan.	• Not met.
• Conduct self-assessment of attitudes of FGC staff, partners and community members towards families w/mental health needs.	• Tool developed and self-assessment conducted with 85% of FGC staff; Tool implemented with 2 key partners per FGC; Tool implemented by one community group per FGC.	• Not met.
• Implement a research study on results of self-assessment.	• (none noted)	• Not met.
2.3 *Increase broader community involvement and development of resources to support children and youth and their families.*		
• Training and mentoring provided to all CAMHD staff to partner with HFAA to promote the CSP and strengths-based planning model. • Engagement of families will continue to be a priority, and targeted training will be ongoing. • Promote youth participation in planning.	• 85% compliance with CSP quality indicators. • Engagement of families and continued training occurs. • 50%/85% of youth participating in the CSP process statewide; 80% of youth participating satisfied with services (Youth Satisfaction Survey).	• Met (partial). Integrated Performance Monitoring Reports • **Met.** Based on feedback from FGC, supervision and training documents. • **Met.** CSP audits review for youth participation.

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Implementation Strategy	Performance Measure	Status Report at December 2004
• Participate in community-based organizations (i.e. Rotary, Chamber of Commerce, etc.).	• All relevant local community organizations identified; BCs presented to 85% of the identified groups.	• **Met.** Documented in supervision process.
• Begin to develop peer education/mentoring/tutoring program.	• Development begins.	• Not met.
• Peer education/mentoring/tutoring. Each FGC to develop a program in partnership with a community organization.	• Each FGC has developed a program in partnership that addresses recruitment of teens as peer tutors/mentors; Each FGC has a memorandum of agreement with 2 community organizations.	• Not met.
• Support local naturally occurring community-based after school/weekend programs that will assist youth in transitioning to adulthood. Focus on self-determination, independent living skills, work readiness and pre-vocational skills.	• Support provided.	• Not met.
• Routine review of service gap reports with particular attention to availability of mental health services in rural communities, with development of services after a gap is identified.	• 85% of children/youth residing in rural communities will be served without experiencing gaps in service.	• **Met.** Integrated Performance Monitoring Reports.
• Development of a plan to include consultation and technical assistance for pre-schools and other early-childhood programs.	• Plan for consultation and technical assistance for pre-schools and other early-childhood programs is completed.	• **Met.** MOA with Early Intervention Section provided funding for PROJECT COACH.
• Continue use of Block Grant funding to support services to homeless and transgender youth, and for early-intervention services.	• 85% of Block Grant performance measures will be achieved	• **Met.**

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Implementation Strategy	Performance Measure	Status Report at December 2004
Goal 3: CAMHD and its provider agencies will consistently apply the current knowledge of evidence-based services in the development of individualized plans. The design of the mental health system will facilitate the application of these services. **3.1** *Achieve the widespread availability of evidence-based services*		
• Conduct training for providers in evidence-based services as identified by CAMHD/EBS. • Develop a network of trainers in evidence-based services. • Develop care coordination supervision model and provide training to MHS-1s on how to supervise MHCCs use of evidence-based decision-making and best practices for care coordination.	• 85% of CAMHD providers and FGC staff will receive training in relevant evidence-based services; 50% of trainers trained. • A care coordination supervision model developed and 85% of MHS-1s trained on the use of it.	• Not met. Supervision training plans document training for FGC staff. Training for CAMHD providers has begun. • **Met.** The Clinical Services Office developed an individualized supervision plan model and provided training to all staff. All supervisors were provided training in use of the "dashboards" as clinical supervision tools.
• Develop Provider Supervision model and provide training to agencies on how to supervise the use of evidence-based services. • Develop a network of trainers in evidence-based services.	• Provider Supervision model developed and 75% of agencies are trained on the use of it. • Network of individuals will be identified to become trainers with at least one trainer per evidence-based services track.	• Not met. • Not met
• Develop high quality training curricula and fact sheets regarding evidence-based services and best practices.	• Evidence-based training curricula and fact sheets will be available.	• Met (partial). Evidence-based service menus created. Some curricula are available but have not been widely disseminated. Fact sheets on dissemination have not been developed.
• Provide training in evidence-based decision making for FGC Staff and prepare them for stakeholder meetings to discuss evidence-based services and principles.	• FGC leadership will be trained and prepared to facilitate stakeholder meetings to discuss and clarify evidence-based decision-making; 50% of FGC staff trained and prepared.	• **Met.** Training and supervision records available. Training has been provided on facilitating meetings, and approximately 50%of FGC staff have been trained in assisting teams in making evidence based decisions regarding service delivery.

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Implementation Strategy	Performance Measure	Status Report at December 2004
• Assure monitoring protocols include evidence-based services and CASSP.	• Monitoring protocols include evidence-based services and CASSP.	• **Met.** Integrated Performance Monitoring Reports.
3.2 *Establish a mechanism for the ongoing evaluation of the use and effectiveness of evidence-based services.* • Completion of evaluation tools and strategies for measuring the use of evidence-based approaches, including monitoring protocols. • Assess impact of current practice on family and provider satisfaction through Provider Satisfaction Survey and Family Satisfaction Survey. • Assess impact of current practice on outcomes, and utilization patterns.	• Tools and strategies developed. • For each survey, data from 20% of registered CAMHD population will be gathered. • Data gathered from 65% of the CAMHD registered population.	• **Met.** Integrated Performance Monitoring Reports, Annual Evaluation Report FY03, Monthly Treatment & Progress Summary. • **Met.** Consumer Survey Report FY2003, Provider Satisfaction Survey. • **Met.** Annual Evaluation Report FY03
3.3 *Promote the sustained and appropriate application of evidence-based services and principles.* • Develop fact sheets for relevant parties to make relevant knowledge available to address the needs of specific targeted populations.	• Fact sheets for all target populations developed.	• Not met Dissemination of evidence-based information and training are functions supported by and performed by the CAMHD clinical director and evidence-base trainer. The Clinical Director and chair of the EBS Committee returned to the University of Hawaii full-time in June 2003 and there has been significant turnover in the trainer position. Until the CAMHD can identify sustainable leadership in these areas these performance measures will be difficult to meet.

• Conduct stakeholder meetings to promote understanding and appropriate use of evidence-based decision making.
  • Gather feedback from stakeholders about where evidence is absent or inaccessible for key decisions.
  • Begin to convene meetings to coordinate incentives for evidence-based services as part of system design.
	• A representative from 55%/65% of stakeholder agencies provides guidance about key areas that are lacking evidence to inform key decisions, and 65% providing feedback.
	• Complete design protocol.
		• Not met
		• Not met.

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Goal 4: CAMHD and its provider agencies routinely evaluate performance data and apply the findings to guide management decisions and practice development.		
4.1 ***Expand*** *and improve the existing operational evaluation and supervision system based on routine practice measures and timely information that is increasingly clinically relevant and is readily exchanged in collaborative relationships with providers and partner agencies.*		
• Define a standard set of forms and reports that summarize relevant data in a clinically meaningful fashion and clarify relations between data gathering and decision-making.	• Forms and Clinical Report Templates produced and approved; decision making guidelines developed.	• **Met.** CRM, "dashboards" completed and operational. Ongoing revisions will continue.
• Develop CAMHMIS clinical/supervision module to implement data gathering and reporting.	• Clinical module completed and operational.	• **Met.** CRM operational
• Sustain group and individual supervision, case presentations, monthly performance appraisals, individual supervision plans, and CSP audit tools as key supervision strategies.	• 100% of staff with current ISPs; 100% of children and youth with current CSPs; and 85% compliance with CSP quality indicators; 90% completed CAFAS, CALOCUS, and Achenbach CBCL parent data quarterly; improved outcomes on these measures.	• Met (partial). Substantially met % of staff with current ISP. % of children with current CSP ranged from 69% increasing to a July 2004 of 95%. % of CSPs compliant with quality indicators ranged from 73% to 90%. CSP quality indicators include completion of child indicators. Steady upward trend in individual child functioning.
• Provide training and technical assistance on clinical processes and clinical/supervision module.	• Improve training evaluation ratings; increase in # of clinical module reports accessed.	• **Met.** Supervision and training reports.
• Maintain care coordinators as the core mechanism for sharing information among child serving entities.	• Decrease in missing data for inter agency involvement fields in CAMHMIS.	• **Met.** Supervision and training reports.
• Establish or maintain a mechanism for local level interagency management discussion in each district.	• Increase in # of child serving entities participating in local level inter agency management discussions.	• **Met.** Supervision and training reports.
4.2 *A clearly defined, decentralized streamlined quality monitoring and improvement system that involves families, multiple agencies, and internal quality*		

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assurance personnel with clear implications for practice and policy decisions in the context of a knowledge-based learning organization. • Develop operational definitions and procedures of monitoring components for FGCs, providers, internal reviews, and Central Office with input from key stakeholders. • Conduct in-depth reviews of FGC performance, provider performance and overall CAMHD performance measures. • Develop a plan to involve families in evaluation and performance management reviews. • Implement a plan to involve families in evaluation and performance management reviews. • Sustain provider and Central Office reviews at the State level. • Conduct review of FGCs by Central Office. • Refine monitoring protocols as needed. • Explore agreements for interagency monitoring. • Move to internal case-based reviews for provider agencies/less external monitoring based on performance and self-monitoring. • Develop capacity to perform and support special, controlled studies in local areas, including	• Development of review protocols for each monitoring component completed. • Annual reports completed in a timely fashion. • Family participation procedures specified in monitoring protocols. • Increase in the # of family members involved in the review and evaluation process. • Annual reports completed that describe level of performance to guide decentralization. • Annual reports completed that describe level of performance to guide decentralization. • Protocols are revised as needed. • Completed workplan for interagency discussion regarding integrated monitoring. • Increase in the # of provider agencies conducting internal monitoring using case-based reviews. • Special study and evaluation reports completed and appropriately distributed.	• **Met.** Evaluation System Summary FY03 • **Met.** Annual Evaluation Report FY03 • **Met.** • **Met.** • **Met.** • Met (partial). One time reviews were completed. • **Met.** • Met (partial). • Met (partial). • **Met.** Schizophrenia Spectrum Population Report, MedQUEST Population Study, Child Status

Implementation Strategy	Performance Measure	Status Report at December 2004
evaluation of prevention, specific populations, and longer term follow-up. **4.3** *Stakeholder communications that tell our story of success in a user-friendly, digestible and inspirational fashion to professional, legislative and family groups and incorporate their feedback in measure selection, data interpretation and system design.* • Produce daily reports for frontline use and more user-friendly summary reports and newsletters, and provide additional professional support. • Develop a media plan • POS contract with a PR agency to provide technical assistance to CAMHD for marketing, including district newsletters. • Revise annual summary report and solicit feedback about desired content from key stakeholders. • National presentations and publications build internal capacity through training and increased data availability, partner with external researchers • Continue to build internal capacity to present and publish on a local and national level through training and increased data availability, partner with external researchers.	• Array of clinical summary reports available for retrieval on a daily basis. • Newsletter, press releases, and media coverage developed. • Annual summary report revised. • Increase in # of published articles and national presentations. • Increase in # of published articles and national presentations.	Measurement Improvement Study • **Met.** • Met (partial). • **Met.** • **Met.** • **Met.**
Goal 5: The business practices implemented throughout CAMHD and its provider agencies ensure high quality and accountable operations. **5.1** *All CAMHD staff need to understand their roles and responsibilities, scope of authority, and be held accountable for their performance.* • Conduct a detailed workflow analysis for CAMHD. • Develop a Staffing/Business Plan to address results of analysis, including discussion of relevant	• Workflow analysis completed. • Staffing/Business Plan developed	• Met (partial). Contracts and Fiscal Management completed reviews. • Met (partial). Staffing plan requires a formal reorganization.

Implementation Strategy	Performance Measure	Status Report at December 2004
positions and position descriptions and any necessary supporting training requirements. • Update all relevant PDs. • Identify training needs tied to specific positions/functions and incorporate into CAMHD Training Plan. • Integration of HIPAA requirements into daily practice of CAMHD and its provider agencies. • Revision of all relevant P&Ps and development of new P&Ps where necessary. • Training of all CAMHD staff on all HIPAA-revised and newly developed, P&Ps. • Provision of consultative assistance to provider agencies as they work to become HIPAA compliant. • Update and revise the CAMHD employee handbook. • Develop an orientation and expanded mentoring program. • Develop in-service training courses targeted towards major portion of CAMHD staff. • Integration of HIPAA requirements into daily practice of CAMHD. • Monitoring of compliance efforts. • Provision of in-service training courses for all of CAMHD staff.	• 100% of PDs will be updated where necessary. • Revision of the CAMHD Training Plan initiated. • CAMHD is HIPAA compliant as required by November 2004. • All P&Ps revised and/or developed. • All CAMHD staff trained. • Provider agencies receive adequate consultative assistance. • Employee handbook revised. • Orientation program/plan developed and implemented. • In-service training course curriculum developed and initial trainings have begun. • HIPAA compliance. • 100% of CAMHD staff have received appropriate trainings.	• Met (partial). • Met (partial). • **Met.** • **Met.** • **Met.** • **Met.** • **Met.** • **Met.** • **Met.** • **Met.** • Met (partial).
5.2 *Consistent enforcement of fiscal management processes to ensure good business practice, fiscal responsibility, and system accountability.* • Appropriate facilitation and application of the competitive bid process whenever possible.	• Little to no appeals of RFP awards, or resolution of RFP appeals in CAMHD's favor by the SPO.	• **Met.**

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• Compliance program with comprehensive claims review and post-review analysis is completed.
• Implement the Utilization Management (UM) Plan to conduct targeted utilization review of most costly services.
  • Expansion of resources and service capacity.
  • Interaction and collaboration with Juvenile Justice System.
  • Consistent oversight of provider agencies.
  • FGC Psychiatrists/Clinical Directors co-manage cases at the higher hospital-based residential level of care.
  • Regular review of established thresholds.
  • Assure that utilization and flow of youth moving to and from more intensive services are examined and monitored on an ongoing basis.
	• Analysis completed and recommendations implemented.
	• Consistent decrease in placements and length of stay in mainland placements, hospital-based residential placements, and out-of-home placements.
		• **Met.**
		• Met (partial). Annual Evaluation Report FY03

• Development of clear protocols around the routing and review of the monthly *Summary of Services*.	• Protocol developed and implemented.	• **Met.**
• Timely completion of monthly *Summary of Services*.	• *Summary of Services* timely.	• **Met.**
• Define the requirements necessary to automate CAMHD's accounting function to allow CAMHMIS to properly interface with DAGS accounting system.	• Requirement defined.	• **Met.**
• Completion and implementation of CAMHD automated accounting function to allow CAMHMIS to properly interface with DAGS accounting system.	• CAMHD automated accounting function completed and implemented.	• Not met. Concluded not required.
• Performance of semi-annual MHCC caseload analysis.	• MHCC caseload analyzed two times per year.	• **Met.**
• Fully implement PAS requirements for all CAMHD staff.	• 100% of staff have updated/current PAS.	• **Met.** Substantially met.
• Strict internal adherence to 30-day reimbursement goal.	• Decrease in amount of 30-day	• **Met.** Substantially met.

Implementation Strategy	Performance Measure	Status Report at December 2004
• Consistent monitoring of compliance with each section/Branch budget. • Completion of billing pre-screen edits. • Claim audits performed based on a random sample of all claims submitted during the fiscal year, and results will be extrapolated to the full set of claims.	reimbursement goals missed. • All sections within CAMHD are operating within their budgets. • 75% of claims reviewed are acceptable. • Reduction in CAMHD overpayment to agencies; no successful challenges to the random sampling methodology through the CAMHD appeals process or through other formal processes.	• **Met.** Substantially met. • **Met.** • **Met.**
5.3 *Implementation of a Strategic Management Information Systems Plan that will allow for identification of the appropriate systems direction for the CAMHD and how it can further utilize technologies to facilitate meeting its mission, goals, and objectives.*		
• Implementation of MedQUEST-required HIPAA modifications.	• Full implementation of MedQUEST-required HIPAA modifications.	• **Met.**
• Implementation of HIPAA requirements that affect Provider Reporting and Billing system.	• CAMHMIS is HIPAA compliant.	• **Met.**

• Workstation upgrades for FGCs and Central Office (hardware and software operating systems).
  • Installation of secure broadband networks that supports necessary communications.
  • Secure funding for these upgrades.
	• Required funding secured; secure broadband network installed; all FGC and Central Office workstations upgraded.	• **Met.**

• Consistent fiscal year systems maintenance and modifications on an annual basis.	• CAMHMIS is current and updated to match the existing needs prior to the beginning of the new fiscal year.	• **Met.**
• Development of a Clinical Supervision module to promote greater capacity and enhance performance of the CAMHD provider network.	• Completion and implementation of the Clinical Supervision Module.	• **Met.**
• Website is regularly updated with updated information, news, documents for publishing, and other information for public access.	• Website is current, user-friendly, and accessible.	• **Met.** Reformatted web site to be consistent with DOH.

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• Comprehensive computer training of CAMHD staff.
  • Orientation to CAMHMIS and email for new users.
  • Oracle Discoverer Training for all users.
  • Microsoft Word training for new users.
  • Microsoft Excel training for specialty users.
  • Microsoft Access training for interested specialty users.
  • Clinical Module training.
  • Training on new modules as developed.
	• Improvement of CAMHD staff competency in all defined areas: decrease in requests for MIS assistance in these areas.	• Met (partial). Based on feedback and supervision, no beginning performance measure to evaluate increased competency or decreased requests.

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Appendix B

Determination of performance measures as Met, Met (Partial) and Not Met was made discussions with the Chief of the CAMHD, Central Office and FGC leadership and staff, providers, community stakeholders, Department of Education representatives and the following documents were used as noted:

UCSF June '04 or External Evaluation Report 2 - Rosenblatt, A., Hilley, L., Thornton, P., (2004) Evaluation Frameworks: Hawaii Department of Public Health's Child and Adolescent Mental Health Division (CAMHD) University of California San Francisco Child Services Research Group

UCSF Oct. '03 or External Evaluation Report 1 - Rosenblatt, A., Hilley, L., Thornton, P., Frank, K., (2003) Evaluation Frameworks: Hawaii Department of Public Health's Child and Adolescent Mental Health Division (CAMHD) University of California San Francisco Child Services Research Group

MedQUEST Quality Review or External Quality Review - Health Services Advisory Group, (2004) 2004 Annual On-Site Review of Quality Assessment and Performance Improvement for CAMHD Phoenix, Arizona

Integrated Performance Monitoring Reports - Quarterly Reports, April 2003 through September 2004.

Consumer Survey Report FY03 - Daleiden, E. (2003) Consumer Survey Report Fiscal Year 2003: Year to Date Honolulu, HI, Hawaii Department of Health Child and Adolescent Mental Health Division

Annual Evaluation Report FY03 - Daleiden, E (2003) Annual Evaluation Report Fiscal Year 2003, Honolulu, HI, Hawaii Department of Health Child and Adolescent Mental Health Division

PI Recomm. Addendum to FY03 Eval. - Daleiden, E (2003) Performance Improvement Recommendations: Addendum to Annual Evaluation Report Fiscal Year 2003, Honolulu, HI, Hawaii Department of Health Child and Adolescent Mental Health Division

Evaluation System Summary - Daleiden, E. (2003) Evaluation System Summary, Honolulu, HI, Hawaii Department of Health Child and Adolescent Mental Health Division

Child Status Measurement: System Performance Improvements During Fiscal Years 2002-2004 - Daleiden, E. (2004) Child Status Measurement: System Performance Improvements During Fiscal Years 2002-2004, Honolulu, HI, Hawaii Department of Health Child and Adolescent Mental Health Division

This Appendix includes terminology defined in the narrative of the report titled **Progress toward fulfilling the Strategic Plan - 2003-2006 and Accomplishments,** December 2004. This Appendix should be used only in conjunction with the full report and Appendix B and C.

Child and Adolescent Service System Program (CASSP) Principles referred to as Guiding Principles (Hawaii CASSP) in this document.

1. The system of care will be child and family centered and culturally sensitive, with the needs of the child and family determining the types and mix of services provided.

2. Access will be to a comprehensive array of services that addresses the child's physical, emotional, educational, recreational and developmental needs.

3. Family preservation and strengthening along with the promotion of physical and emotional well-being shall be the primary focus of the system of care.

4. Services will be provided within the least restrictive, most natural environment that is appropriate to individual needs.

5. Services which require the removal of a child from his/her home will be considered only when all other options have been exhausted, and services aimed at returning the child to his/her family or other permanent placement are an integral consideration at the time of removal.

6. The system of care will include effective mechanisms to ensure that services are delivered in a coordinated and therapeutic manner, and that each child can move throughout the system in accordance with his/her changing needs, regardless of points of entry.

7. Families or surrogate families will be full participants in all aspects of the planning and delivery of services.

8. As children reach maturity, they will be full participants in all aspects of the planning and delivery of services.

9. Early identification of social, emotional, physical and educational needs will be promoted in order to enhance the likelihood of successful early interventions and lessen the need for more intensive and restrictive services.

10. The rights of children will be protected and effective advocacy efforts for children will be promoted.

Developed by Hawaii Task Force, 1993.
(Adapted from Stroul, B.A. and Friedman, R.M., 1986)

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Appendix C Glossary

Best Practice - Expert consensus opinion regarding a preferred course of action or standard of care in the absence of research evidence from controlled scientific studies supporting its effectiveness.

Care Coordination - Activities involved in serving as central point of contact for a family. Functions include coordinating the mental health services, linking with all involved child serving agencies, monitoring provider delivery of service, assisting child/youth and family with accessing and receiving necessary services. Includes home visits, school visits, provider meetings, and routine evaluation of results of service delivery. Often referred to as intensive clinical case management in other agencies.

Child Serving Agencies - Most commonly used to identify the public agencies responsible for various aspects of supporting and serving children and families. Typically implies the Department of Education, Department of Human Services for Child Welfare Services, Child & Adolescent Mental Health Division, Office of Youth Services and Juvenile Justice.

Child/Children - An individual(s) age birth through 12 years.

Clinical Report Module (CRM) – Also known as "dashboards", the CRM provides customizable screens to track changing treatment issues.

Community Children's Council (CCC) - The organizational foundation for community participation in the system of care established in accordance with the Felix Consent Decree.

Coordinated Service Plan (CSP) - A written design for service that describes the roles and responsibilities of multiple agencies or programs that provide therapeutic or supportive interventions or activities essential to the youth's and family's treatment.

Coordinated Service Plan (CSP) Process - A process of bringing together the family, multiple agencies and providers, and the child/youth, when appropriate, to develop a comprehensive and integrated plan of individualized care for the child/youth that is based on the child's/youth's strengths and needs.

DSM-IV - A publication titled the Diagnostic and Statistical Manual of Mental Disorders that is used to guide diagnostic formulations of individuals with emotional disorders.

Emotional Disturbance - An emotional or behavioral condition, categorized by a DSM IV diagnosis, which impacts the functioning of many children/youth.

Empirically-Supported Services - A subset of "evidence-based" techniques (see "Evidence-Based" in this Glossary) that have met a particular set of more demanding criteria for their support and use as mental health treatments. These criteria were outlined nationally by the American Psychological Association Task Force on Psychological Intervention Guidelines (1995) and have been adapted locally by CAMHD. The two criteria that distinguish "empirically-supported" from other "evidence-based" techniques are: 1) efficacy, or how well a treatment is known to bring about change in the problem, and 2) effectiveness, or the clinical utility of the intervention. Whereas efficacy is mainly concerned with the quality of treatment in controlled, often university-based programs, effectiveness refers to the expected or observed performance of a treatment in a "real world" setting.

Evidence Based Decision-Making - The process of prioritizing therapeutic services for use based on the quality of national, local, and individual evidence regarding the likely outcomes and effectiveness of those services.

A common example is to give preference to the use of services with clear scientific support in multiple randomized clinical trials or well-controlled clinical series, before services support by non-randomized studies, uncontrolled studies, or expert consensus.

Evidence Based Services - Those strategies and interventions, identified by the EBS Committee, for which credible, published research exists demonstrating positive effects, including uncontrolled, open trials or case studies. For the purposes of the CAMHD, such evidence typically is found only in peer-reviewed scientific journals.

Evidence Based Services (EBS) Committee - An interdisciplinary committee responsible for routinely reviewing and reporting on the scientific literature to identify evidence based services and best practices. Members represent multiple stakeholder groups including CAMHD, DHS, DOE, Family Court, Families, Providers, and the University of Hawaii.

Health Insurance Portability and Accountability Act (HIPAA) - An Act of Congress that amends the Internal Revenue Code of 1986 in order to improve the portability and continuity of health insurance coverage. The Act primarily seeks to protect the confidentiality and privacy of patient health information and requires the development of a health information system, including the standards and requirements for the secured electronic transmission of certain health information and for policies and procedures in compliance with HIPAA's Privacy Rule.

Individualized Special Education Information System (ISPED) – The Department of Education's information system for collecting core data elements for youth with educational disabilities.

Knowledgeable Staff - Individuals that have been formally educated or received professional training to work with a given population.

Oracle Discoverer - Discoverer is a distributive on line reporting system that allows custom data sets to be reported and manipulated based on access rights. Users have the ability to drill down on specific information or export data sets into Excel.

Performance Appraisal System (PAS) –The Performance Appraisal System provides supervisors with an effective tool to evaluate, and improve, employees' work performance.

Provider(s) - The network of agencies and their subcontractors from which CAMHD purchases direct services for children, youth, and families.

Sentinel Event - An occurrence involving serious physical or psychological harm to anyone or the risk thereof. (See CAMHD Sentinel Events Policy and Procedures for event code definitions and reporting requirements.) A Sentinel Event includes 1) any inappropriate sexual contact between youth, or credible allegation thereof; 2) any inappropriate, intentional physical contact between youth that could reasonably be expected to result in bodily harm, or credible allegation thereof; 3) any physical or sexual mistreatment of a youth by staff, or credible allegation thereof; 4) any accidental injury to the youth or medical condition requiring transfer to a medical facility for emergency treatment or admission; 5) medication errors and drug reactions; 6) any fire, spill

of hazardous materials, or other environmental emergency requiring the removal of youth from a facility; or 7) any incident of elopement by a youth.

Serious Emotional Disturbance or Serious Emotional/Behavioral Disturbance (SED/ SEBD) – An emotional or behavioral condition which greatly impacts the functioning of many children/youth. Typically the individual meets the following criteria:

- From birth to 18 years

AND

- Who currently, or at any time during the past year have, or had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria of the Diagnostic & Statistical Manual for Manual Disorders, Vol. IV. (DSM IV)

AND

- This diagnosis resulted in functional impairment ***that substantially*** interferes (d) with, or limits, the child's role or functioning in family, school, or community activities.

AND

- These disorders *exclude* V codes, substance use, and developmental disorders, *unless* they co-occur with another diagnosable serious emotional disturbance.

Stakeholders – Individuals, entities and agencies that have a vested interest in the children's mental health system, including families, community associations, advocacy groups, child serving agencies, and the legislature.

System –The resulting whole, whose elements stay together because they continually affect each other over time and operate toward a common purpose.

System of Care - A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families.

Young Adult – An individual, age 19 to 21 years.

Youth – Most broadly may be used to refer to individuals ages 3 – 20 years, but most commonly use refers to individuals, age 13 through 18 years.

happy children • healthy families• helpful communities

naragsak nga ubbing• dagiti nasalun-at nga pamilia•
makatulong nga komunidad

mga batang masaya • malusog na pamilia milia• matulungin na komunidad

快樂的兒童◦健康的家庭◦互助的社區

행복한 아동들◦건강한 가족들◦서로돕는 공동사회

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Hawai`i State Department of Health
▪ healthy people ▪ healthy communities ▪ healthy islands